Ambulatory Care Response To Pandemic Influenza:

Contingency Plans, Long Term Recommendations, And Tools

A report produced by the
King County Health Care Coalition
in collaboration with
Public Health – Seattle & King County

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AMBULATORY CARE RESPONSE TO PANDEMIC INFLUENZA: CONTINGENCY PLANS, LONG TERM RECOMMENDATIONS, AND TOOLS
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Chapter I: Introduction

Emergency Preparedness Planning

This document (referred to hereafter as the plan) addresses the special issues that the ambulatory care community must address in order to be prepared for all emergencies, but for pandemic influenza most immediately. In December, 2005, the King County Executive, Ron Sims, charged Public Health–Seattle & King County (PHSKC) with drafting the plan by June, 2006. Because the majority of ambulatory care is provided by the private sector, PHSKC convened the Ambulatory Care Preparedness Working Group (ACPWG) as part of the King County Healthcare Coalition. Therefore, this document represents only one facet of larger planning efforts in the regional medical system.

The King County Healthcare Coalition is a network of healthcare organizations and providers committed to coordinating their emergency preparedness and response activities. Specifically, the Coalition aims to develop a system that assures effective communications and optimal use of healthcare resources during emergencies. The Coalition includes senior management, clinical, and operational representatives of all hospitals, major health care organizations and partners in King County.

The ACPWG includes representatives of most outpatient health care sectors (medical clinics and offices, the Emergency Medical System, telephone medical help lines, etc.) in King County. The ACPWG aims to assure that the ambulatory care community can meet the demands of emergencies. In particular, because natural disasters (such as earthquakes or a worldwide influenza pandemic) and man-made emergencies (such as chemical spills or bioterrorism) can trigger a sharp increase in the number of patients needing evaluation and treatment, the ability to rapidly increase clinical capacity is a critical component of a community's emergency preparedness. Pandemic influenza could challenge the usual strategies to meet demand because there may be no external agencies (local, state, or Federal) with resources to spare.

Although the plan is intended to assure that the ambulatory care community can respond to any emergency, the most pressing concern is response to pandemic influenza. Therefore, the plan is built around scenarios for pandemic influenza, assuming that a health care system prepared to respond to the potentially extreme demands of pandemic influenza will be prepared to respond to other emergencies.

The World Health Organization (WHO) and the U.S. Department of Health & Human Services (DHHS) have defined specific stages of a pandemic. These are presented in Appendix A (Potential Scenarios for Pandemic Influenza in King County). The WHO and DHHS stages take an international and national perspective respectively, which is appropriate for these international and national agencies. However, action at the local level will depend largely on local conditions. Therefore, the plan uses the WHO and DHHS stages to assure consistency in communications, but expands the later WHO and DHHS stages to address local action.

Pandemic Influenza

It is not possible to predict the specific characteristics or timing of the next human influenza pandemic. Although pandemic influenza will likely derive from avian influenza, avian influenza in birds or humans will likely occur before a human pandemic virus emerges that can spread readily among people. If avian influenza arrives in our region before a human pandemic virus, there may be sporadic human cases of avian influenza among persons exposed to infected animals locally. Currently, only persons traveling internationally to areas with outbreaks of avian influenza are at risk. In this scenario, the focus for clinicians will be on rapidly identifying and reporting suspect cases using standardized screening criteria, implementing appropriate infection control measures (potentially in coordination with PHSKC for home isolation), obtaining appropriate diagnostic tests, clinically managing suspect and confirmed cases, and providing appropriate information and counseling to exposed persons and the public. This scenario is relatively uncomplicated and the demand for health care services is not expected to exceed capacity.

With a virus capable of human-to-human transmission, the situation is more complicated. The ultimate impact of the next pandemic will depend on the severity of illness, the rapidity with which the virus spreads, and the populations affected. Again, the focus will be on careful ascertainment of cases, appropriate infection control measures, clinical care for infected individuals, and providing accurate information. However, assuring continuity of services in clinical settings and monitoring for illness among healthcare workers may now be necessary.

In a severe pandemic, public health measures to decrease the spread of infection in the community would likely be instituted. Hospitals would provide clinical care (including isolation precautions) for the most severely ill; less severely ill persons would need care at home. In a severe pandemic with widespread illness in the community, hospital capacity would likely be exceeded. In this setting, there is a need to provide basic medical care to the majority of ill persons outside the hospital setting, either at home, in existing ambulatory care facilities, or at yet to be identified alternative care sites (e.g., hotels, schools, arenas, or stadiums).

In a large-scale health emergency, altered standards of care would be necessary in order to manage the surge in ill patients. It is important to identify and address the legal and/or regulatory implications associated with use of altered standards of care during such an

emergency, so that medical providers feel secure in applying such standards without fear of lawsuits. Legal issues include allowing health care providers to practice outside their usual scope of practice and use of non-medical personnel to assist in providing medical care. As noted earlier, in the late stages of a severe influenza pandemic, external resources are not likely to be available and the health care community will have to rely on local resources.

In every scenario, communication will be critical. Public health agencies must assure that the lay public and health care professionals are informed about the status of the emergency. The public will need to know when to remain at home, how to manage at home, and how to get medical attention if needed. The health care community will need to know the status of hospitals and other resources (such as antiviral medications), current triage and treatment protocols, and how to get assistance if needed and available. Conversely, the health care community must inform public health about the impact of the pandemic on their patients and their ability to maintain services.

Ambulatory Care Workgroup Process

For the initial ambulatory care stakeholder meetings, PHSKC issued invitations to more than 50 health care professionals representing more than 30 health care organizations. Separate meetings were held February 27 in Seattle and February 28 in Bellevue. Both of these meetings followed the same agenda, focusing on developing the initial list of key issues that a plan must address. A subset of participants at the initial meetings was constituted as the Ambulatory Care Preparedness Working Group (ACPWG). In response to ACPWG suggestions to assure representativeness, providers representing additional health care sectors/organizations were invited to join the group (see Appendix B for final list). In order to draft a plan by the end of June, 2006, the ACPWG met seven times during April through June, 2006, with extensive e-mail communications between meetings. Between the ACPWG monthly meetings, PHSKC staff researched questions raised by ACPWG members, identified additional resources bearing on ACPWG issues, and drafted plan sections.

To assure that the plan adequately reflected the ambulatory care community's issues, community members were offered three levels of participation. ACPWG members received all plan drafts and background information, attended the ACPWG meetings, and were expected to review and comment on the drafts. Other community members were offered two levels of participation. "Reviewers" received all plan drafts and background information. "Observers" received regular summaries of ACPWG work and could request plan drafts and background information. Both "Reviewers" and "Observers" were encouraged to offer feedback. The final document was adopted by the ACPWG on July 18, 2006.

Once adopted formally this document will be made widely available by posting on the Healthcare Coalition Website and through the existing dissemination processes of our community partnerships, such as the King County Medical Society.

Plan Review and Updates
Informally, during development, members of the ACPWG piloted parts of this plan in their own agencies. (Multicare and Polyclinic). However, to assure that plans reflect the most current information and available resources, it will be assessed and updated at least annually by representatives from the Ambulatory Care Workgroup.

Overarching Principles and Key Strategies

The Working Group wrestled with overarching principles that could reflect provider commitment to their patients, their own families, and their communities. The group endorsed these overarching principles, that any responses to major emergencies must:

1. Assure that society will continue to function;
2. Reduce deaths and hospitalizations;
3. Minimize barriers to access for all; and
4. Keep the infected away from the uninfected, as much as possible.

The Working Group also endorsed several general strategies (that are detailed elsewhere):

1. Educate the public before a pandemic;
2. Assure that providers get early alerts and regular updates;
3. Assure that telephone triage is available and widely promoted;
4. Develop alternate care sites; and
5. Plan for rationing care based on the U.S. Department of Health & Human Services guidelines (high to low priority: hospitalized patients, health care workers, immunocompromised persons, support workers, elderly & young).

Key Components

This plan is organized around *key components* identified through the two community meetings held in February 2006. For each key component, the plan defines the *scope* of how the issue will be addressed and presents the guiding *principles* that serve as the foundation for *goals*. Discussions of scope directly tailor the boundaries of planning and indirectly identify areas of planning for other workgroups of the Healthcare Coalition. The principles section serves as a framework for understanding the priorities and values of the Working Group in the planning effort. Finally, the goals section identifies the desired outcome, existing resources that support the achievement of the outcome, gaps in the system, and resources and recommendations for further planning or infrastructure development. Because a pandemic could occur before the plan is fully implemented, recommendations are presented as *contingencies* (expected actions based on current resources and policies) and *long-term recommendations* (actions based on resources and policies developed in response to gaps). Contingencies have not necessarily been vetted by all parties, but are reasonable actions where alternatives do not exist. During an emergency, unfolding events may lead to on-the-fly decisions that supersede the contingencies listed in the plan.

Because time and resources were limited, some topics were not addressed during Working Group meetings, but were recognized as deserving further discussion and potential inclusion in the plan. Specifically, the issues of long term care settings (congregate housing, nursing homes, etc.) and vulnerable populations (homeless, non-English-speaking, etc.) must be addressed. The Working Group expects that these issues will be incorporated into this or other PH-SKC and Healthcare Coalition preparedness plans as they are further reviewed and ultimately implemented.

Chapter II: Key Components

Communications

Scope

The scope of planning for communications is limited to the interactions between PHSKC and the Ambulatory Care community through the King County Healthcare Coalition. Specifically, this plan seeks to assure that mechanisms are in place for PHSKC to communicate to ambulatory care providers the status of an event and its recommendations as well as for PHSKC to receive information about the logistical status of the ambulatory care system during events.

Principles

The principles underlying the planning effort around communications between the Regional Medical Resource Center (RMRC) and the ambulatory care community are redundancy, simplicity and efficiency. Appropriate, coordinated and efficient emergency response depends on the ability of agencies and providers to communicate during events. Reliance on one method of communication can severely limit the ability of stakeholders to participate and support one another. Therefore, redundant communications systems and methods increase the likelihood of having open channels of communication. However, having a means to communicate is not sufficient to ensure appropriate, coordinated and efficient response. Emergency events naturally cause increased chaos and confusion, therefore, attention to the process of communication is necessary. Simplicity in how information is communicated, the initiation of communications and the timeliness of subsequent communications all support an infrastructure that will guide the coordination of response.

Plan of Action until future plans are complete

In the event of an emergency:

Public Health will notify providers via Info X and Facsimile. Additionally, Public Health will post the most current information on its website.

ALL PROVIDERS SHOULD:

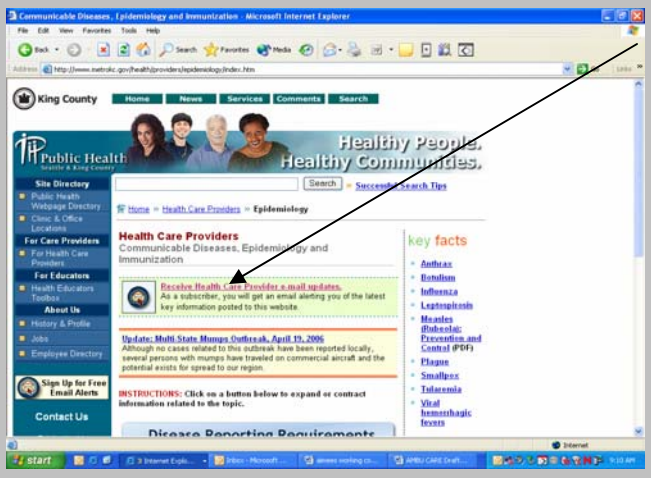
1) Subscribe to Info X:

Send an e-mail message to tiffany.acayan@metrokc.gov with:

- Your name and professional title (i.e., infection control professional, clinical nurse, administrator, physician, etc)
- E-mail address
- Practice location
- Practice type (i.e., primary care, obstetrics, pediatrics, infectious disease, etc)

2) Sign up to receive notice of updates to the Public Health website:

a) go to http://www.metrokc.gov/health/providers/epidemiology/index.htm
b) select the link to "Receive Health Care Provider e-mail updates Sign Up for Free E-mail Alerts"
c) enter your e-mail address
d) you will receive updates via e-mail as appropriate



3) Subscribe to the Public Health "Broadcast Fax" system by sending and email to Ruby Lopez at Ruby.Lopez@metrokc.gov. Include the practitioner or clinic name, specialty and fax number.

4) Ensure the appropriate distribution of incoming faxes to staff within their organizations.

5) Ensure access to the internet and bookmark the appropriate Public Health webpage: http://www.metrokc.gov/health

6) To speak with a public health official, call the 24 hour Duty Officer line at 206-296-4606

King County Medical Society will forward all PHSKC fax and e-mail alerts.

The Public Health EOC will call key contacts at Polyclinic, Minor & James, University of Washington Physicians Network, and Harborview Clinics to obtain operational status during a pandemic.

Future Planning Goals

I. Assure messages from Regional Medical Resource Center and PHSKC can reach providers during emergency events.

Consistent with the principle of redundancy in methods of communication, the following technologies will be considered for further planning. Ultimately, a communications inventory and usage plan should be created for ambulatory care providers that comports with existing communications technologies and procedures used by area hospitals, County emergency planning and response agencies and other partners.

Technologies

Fax

The fax machine will be used during emergency situations because it is readily available, there are no barriers to interoperability between locations or models, and they serve as a good way to transmit data in a standardized manner. While all ambulatory care providers have fax capabilities on site, and PHSKC has a well-developed system for sending faxes to multiple locations simultaneously, additional planning is necessary to maximize the efficient use of this technology. The "Broadcast Fax" system is currently available and used. It is assumed that the Regional Medical Resource Center will also utilize fax capabilities.

(1) End user attention to and process for information dissemination within offices needs improvement. Ambulatory care providers should develop standardized methods of fax alert dissemination within offices to ensure that the appropriate operational and decision-making staff are aware.

(2) PHSKC should review the appearance of the fax alerts to ensure that standardized coversheets identify urgent matters are not easy to overlook.

(3) While PHSKC has a system in operation for mass faxing, many ambulatory care providers are not on the contact lists utilized by PHSKC. All ambulatory care providers should provide PHSKC with current fax numbers. The King County Medical Society (KCMS) is prepared to duplicate and customize faxes to all members, so PHSKC should also continue to work with KCMS to assure effective communications with KCMS members. Even if KCMS faxes duplicate faxes sent directly from PHSKC to providers, such redundancy during emergencies is appropriate.

(4) Finally, PHSKC should establish and refine a process for continual maintenance of the list of fax numbers and test the system periodically.

E-mail

E-mail will be used during emergencies because it is widely available, it allows for simultaneous communications throughout the community and can transmit data easily. While many providers have e-mail addresses and PHSKC has the capability to manage listserves, the current list of provider e-mail addresses represents only 10% of ambulatory care providers. This reflects providers not subscribing to listserves and not having e-mail addresses associated with their offices. Therefore, further development of the e-mail method is needed.

(1) All providers should obtain an e-mail address for their offices and develop protocols for regularly checking the account.
(2) PHSKC should publicize listserv subscription instructions.
(3) The Regional Medical Resource Center should coordinated listserv use with PHSKC to maximize efficiency and prevent overuse of email during emergencies.
(4) All providers with e-mail addresses should subscribe to the PHSKC listserv appropriate for emergency response. KCMS is prepared to issue blast e-mails, info e-mails, auto-e-mails, etc. to all members.
(5) Providers, KCMS, PHSKC and the Regional Medical Resource Center should develop a system of maintenance of address lists and regularly test the system.

Public Health Website

The internet will be used as a method of communication during emergencies because it is widely accessible from a variety of locations, it has the capability of providing information to a limitless number of people simultaneously, and it has document storage capability.

While most providers have access to the internet and PHSKC has the capability of publishing messages to the web, not all providers have internet access at their office sites and the current PHSKC website does not have a secure provider page. Therefore, further consideration and planning are needed to ensure to effective use of the internet during emergency events.

(1) The Ambulatory Care Workgroup would support PHSKC in developing a secure site for provider use during emergencies. The importance of this is to ensure candid and direct communications with the specific target audience, providers and preempt the potential for community panic through wide access to sensitive information.
(2) All providers should ensure access to the internet at their office sites.
(3) The Ambulatory Care Workgroup encourages PHSKC to ensure appropriate staffing levels for web publishing during emergency situations.

Telephone

Allowing for immediate connectivity and conversation, the telephone will be used during emergencies. Several resources exist within this technology. PHSKC has existing capabilities in digital, analog and cellular phone technology, conference call hosting capabilities, and call banking, routing and messaging capabilities. All providers have some telephone capabilities. However, many providers are unaware of differences in technology, no established protocols exist for integrating telephone options, and we remain uncertain about which technologies providers are using. Consequently, more planning and training are needed to maximize the effective use of the telephone during emergency situations.

(1) All providers should become aware of the strengths and weaknesses of analog, digital and cellular technologies and ensure redundancy within their offices.
(2) The Regional Medical Resource Center should develop conference call capability and protocols for conference calling with the ambulatory care community during emergencies.
(3) PHSKC and the Regional Medical Resource Center should develop a mechanism for maintaining contact information for ambulatory care providers and test this method regularly. The KCMS telephone system is designed to provide several different automated messages to the public and members and also can be updated and messages changed from off-site locations. This may be a valuable adjunct to the PHSKC and RMRC systems.

Text Messaging

Text messaging capabilities can serve as a quick and direct alert to the need to obtain more information. In concert with other technologies, text messaging can be an effective and less intrusive means of mobilizing response. While most providers carry pagers, it is unclear how many use pagers capable of receiving text alterts. Furthermore, PHSKC does not currently maintain a contact list or a policy for communication via pager with providers or operational leadership in the ambulatory care community.

Therefore, the ACPWG recommends that the RMRC explore with PHSKC the use of text messaging as a rapid communication tool.
(1) All providers or appropriate organizational leadership should explore the use of alpha capable pagers or cellular phones in order to receive and send text alerts during emergencies.
(2) If this is feasible for regional communications, the RMRC should develop a mechanism for obtaining and maintaining a list of contacts in the ambulatory care community, and should develop a protocol for use of such a list and should test the system regularly once developed.

Amateur Radio

A highly reliable option for communications when other technologies are disrupted, amateur radio has been used during disaster response throughout the world for many years. All PHSKC clinics, local emergency operations centers and hospitals have amateur radios and licensed operators on site. An active local chapter of the Amateur Radio Relay League's (ARRL) Amateur Radio Emergency Service (ARES) has developed a protocol with all hospitals in King County to serve as backup communicators during emergencies. PHSKC's use of amateur radio has only recently become formalized for emergency operations purposes. Furthermore, very few providers in the ambulatory care community have this capability on site.

Therefore, the Ambulatory Care Workgroup recommends:

(1) PHSKC formalize its use of amateur radio and develop protocol for use between sites and EOCs during emergencies.
(2) That the RMRC explore with ARES the possibilities of expanding the network to include geographically key ambulatory care provider sites., how best to obtain training for identified staff in office settings and to develop procedures that include ambulatory care sites in community-wide communications channels.
(3) All providers consider obtaining an amateur radio and identify staff to become licensed operators. (See Appendix D for information on getting started in amateur radio).

Procedures

Once redundancy has been created throughout the ambulatory care community, procedures for use will need to be developed. PHSKC should draft procedures that include: (1) thresholds for message dissemination, (2) guidelines for message content, and (3) prioritization of methods for dissemination. Note that KCMS is working with PHSKC to improve provider communications and to develop and deliver provider training around communications. Ultimately, an alerting plan needs to be developed, in cooperation with King County's master planning efforts, to assure emergency communication with all sectors of the healthcare system in the event some technologies fail.

<u>II. Assure that providers can access specific information as needed.</u>

The multiple communications channels noted above will assure that information can be transmitted from public health to providers. Providers will be responsible for monitoring alerts, by checking their faxes, e-mail, and the public health website. However, providers will undoubtedly have specific questions at times. Therefore, mechanisms enabling providers to contact public health experts are needed, although these may quickly overwhelm the public health network. The existing public health emergency telephone line capacity could be expanded but

an alternative system to address providers needs is developed through the Regional Medical Resource Center.

III. Assure that mechanisms are in place to measure the changing logistical status of providers

A sentinel provider network already exists to monitor infectious diseases in the community. This network can serve as a model for an operational sentinel system to regularly report to the Medical Resource Center and PHSKC about the operational status of the ambulatory care community. The Medical Resource Center could also explore either expansion of the existing Hospital Capacity Website to include ambulatory care indicators or the development of a parallel web-based reporting and monitoring mechanism for the ambulatory care system.

Public Information

Scope

The scope of public information is to ensure that efficient and effective mechanisms exist that will keep lay public well informed about preparations before emergencies and status during emergencies.

Principles

The principles underlying the planning effort around public information are redundancy, simplicity, and efficiency. Well-crafted, timely, and genuine messages can reduce widespread panic and support the response structure by reassuring community members that a reliable response system is in place and they should follow it. Reliance on one method of communication can severely limit the goal of mass and thorough dissemination of information. Therefore, redundant communications systems and methods increase the likelihood of community members receiving information and responding appropriately. However, having a means to communicate is not sufficient to ensure appropriate, coordinated and efficient response. Emergency events naturally cause increased chaos and confusion. Therefore, attention to the process of communication is necessary. Simplicity in how information is communicated, the initiation of communications and the timeliness of subsequent communications all support the goal of keeping the public informed and trusting during emergencies.

Plan of Action until future plans are complete

In the event of an emergency:

Public Health will post appropriate public information on its website.

ALL PROVIDERS SHOULD: Register for Info X (see Communications above) and check Info X alerts and the Public Health webpage (http://www.metrokc.gov/health) for the most updated public and provider information. Sensitive information intended to reach only providers may not be posted on the website. Therefore, registration on Info X is critical.

The public will receive information updates and messages via the normal channels of dissemination used by Public Health.

Future Planning Goals

I. Assure appropriate prevention, care, and social control messages reach the public before and during emergencies.

Mass Communications

Providing the most current information to an anxious public is arguably the most important responsibility of public health. Preparing the public for emergencies and providing regular updates during emergencies will enable King County residents to care for many of the sick and injured at home, relieving demand on the medical system. Therefore, the ACPWG supports efforts of coordination with other public health agencies (such as the Washington State Department of Health), PHSKC immediately develop and implement a campaign for mass communication about pandemic influenza.

Public Information

PHSKC has a communications team and staff surge capabilities responsible for crafting messages to the public during emergencies. This team is well connected with other jurisdictional public information officers. The communications team has drafted a detailed plan for a public information communications center (PICC) that can provide callers to a central telephone number with updated information about public health issues. However, the PICC capacity may be exceeded in the late stages of a pandemic. Based on normal call volume to local ambulatory care healthlines, the ACPWG anticipates substantially increased call volumes during a pandemic. Therefore, the ACPWG suggests that PHSKC increase this capacity to accommodate up to 10,000 calls/day.

Telephone Triage

In the interest of social distancing and prioritization of medical resources, telephone triage will be a critical element in the management of a pandemic locally. The Healthcare Coalition is already working with the Washington Poison Control Center to assess existing call handling/triage systems and develop a plan to meet the demands of a pandemic. The Ambulatory Care Working Group recommends that a telephone triage system be coordinated among existing call handling/triage systems or that a new system be developed. Based on normal call volume to local ambulatory care healthlines, the ACPWG anticipates substantially increased call volumes during a pandemic. The Ambulatory Care Workgroup suggests a call capacity of 20,000 calls/day as the minimum target for such a system.

Coordinated and Easily Accessible

In the interest of reducing public confusion and encouraging confidence in the public, the Ambulatory Care Workgroup recommends that if possible, one number be published for any pandemic influenza information and service.

II. Assure consistency in messaging by ambulatory care providers.

Many providers already distribute public health information and have trusting relationships with patient populations. However, emergency preparedness generally and pandemic influenza specifically have not been a focus of public health messaging through providers in the past. The ACPWG suggests that ambulatory care providers be seen as a primary point of dissemination for public messaging.

As the pandemic influenza campaign is developed by PHSKC, a patient emergency preparedness template based on national templates should also be developed for provider adaptation and dissemination. The ACPWG could participate in this process. This template should include local referral information (e.g., public health information line and medical triage line). Once a pandemic occurs, PHSKC should develop a schedule for public updates on the status of disease in the community. In particular, PHSKC must inform providers early enough and regularly enough to allow them to give their patients/clients messages consistent with public health messages. Note that the KCMS will post both public and provider-specific messages and educational templates on the website and will produce print versions as needed.

III. Assure messages are culturally and linguistically appropriate.

While PHSKC has internal capability and external contracts with medical translators, and some providers have similar capabilities, a system of coordination of these services needs to be developed before the emergency. With continually changing circumstances during emergencies, the length of time it takes to translate written materials precludes the method of "just-in-time" development. Therefore, the medical translation community should be included in all aspects of planning.

Specifically, the ACPWG suggests that in collaboration with the PHSKC Communication Team: (1) template messages be developed by phase of pandemic as early as possible to reduce the time to complete translation during emergencies; (2) an emergency translation team or mechanism that can serve for written and oral translation and respond within 48 hours of an emergency be developed; and (3) the multi-lingual capacity currently present in the ambulatory care community should be explored and coordination points identified.

Site Emergency Operations

Scope

The scope of site emergency operations planning is to ensure maximization of operations as a pandemic unfolds.

Principles

The principles underlying site emergency operations planning are preparedness, efficiency and effectiveness in changing environments during a pandemic. Preparedness includes policies and procedures that support staff, surge capacity in terms of supplies, space and time and coordination and collaboration with other healthcare organizations. Efficiency is the ability of an organization to transition into pandemic operations quickly and with little disruption. This requires that the staff is well trained and practiced in the implementation of a comprehensive site plan. Effectiveness speaks to the ability of an organization to implement a site pandemic plan consistently in such as way as to provide the best service to patients as possible under changing circumstances.

Plan of Action until future plans are complete

All ambulatory care providers should continue to provide service as much as possible.

All providers should rely on current translation capabilities. Information about AT&T Phone Translation Services is available from: 1-877-886-3885

All ambulatory care providers should use the DHHS as a guide to site planning including surge, cache and staffing, and ensure that staff know what is expected of them. (see Appendix C for guidance)

All ambulatory care providers should be familiar with recommended clinical standards, available at: http://www.metrokc.gov/health/pandemicflu/index.htm. and in Appendix E.

I. Assure site preparedeness

In the event of a pandemic, all ambulatory care providers will undoubtedly experience a surge in patient calls and appointments. Each organization should prioritize patient conditions and be prepared to transition to provisions to meet the underlying goals of social distancing for infection control, providing the greatest good to the greatest number of people and business continuity.

Every office should have an individualized plan for business continuity and all staff should be well trained on the expectations of the plan. Medical Directors should take a leadership role within their organizations by ensuring that all staff are trained appropriately. The Ambulatory Care Work Group recommends that Public Health – Seattle & King County provide for regional educational specialists for delivery of training needs throughout the region. Trainings should also be made available via the internet. (See Appendix C for guidance)

II. Increase collaborative efforts within emergency management zones

Providers should familiarize themselves with other providers within their emergency management zone (see appendix C for maps). KCMS has a database of members that can provide home and office location by zip code; PHSKC and KCMS should develop a strategy for alerting providers to others in their neighborhoods. All organizations should engage in zone specific planning and develop appropriate memoranda of agreement for maximizing resources within the zone.

Clinical Care/Standards

Scope

The scope of clinical care is to assure that triage and treatment strategies are appropriate to the community's health status and available resources,

Principles

(1) Providers will work together to assure the greatest good for the greatest number.
(2) In general, care will be provided without discriminating by personal characteristics. However, priorities may shift as an emergency evolves. For example, if surveillance suggested that young adults were more susceptible than older adults or children to pandemic influenza, then resources might be redirected to young adults. Standardized guidelines should be published and updated as appropriate.

Plan of Action until future plans are complete

Ambulatory care providers should refer to Appendix E, attend to any public health alerts, and check the public health webpage at http://www.metrokc.gov/health for triage and management strategies (including antiviral and vaccine availability and distribution) during a pandemic.

Providers should immediately begin distributing the instructions for home care, while also educating patients that elective care will need to be delayed during a pandemic.

Future Planning Goals

I. Assure that ambulatory care clinicians are familiar with and use appropriate standardized guidelines for triage and outpatient management of ill persons during a pandemic response.

Guidelines will be based on current HHS guidance for clinicians. These will be reviewed by the Healthcare Coalition's Medical Director's Work Group (including representatives from ambulatory care organizations).

Standards of care may change during a pandemic, reflecting reduced resources. Laboratory or radiographic services, medications, intensive care services such as ventilators, and consultation may not be available. The guidelines in Appendix E present three levels of triage and management, based on the resources available. These guidelines are currently draft only. The ACPWG recommends quick review and approval by the Medical Directors.

II. Assure that patients are prepared to defer elective care during emergencies.

During emergencies, the ambulatory care community must maximize opportunities to provide urgent care. A key strategy is to defer elective care, freeing up office time for urgent care. The ACPWG suggests that the Healthcare Coalition in coordination with PHSKC develop generic messages about deferring elective care during emergencies, publicize these messages to providers and the public, and provide basic written materials that providers can distribute to patients.

III. Assure that antibiotics and vaccines will be available to the highest priority populations.

The most appropriate antiviral treatments for pandemic influenza may not be known until a pandemic begins. Vaccines are unlikely to be available for months thereafter. However, a Public Health work group is already drafting plans to distribute antivirals and vaccines. Because it is likely that there will not be enough antivirals and vaccines initially, distribution will be limited to priority groups. For antiviral distribution during an influenza pandemic, DHHS guidelines define groups from high to low priority as: hospitalized patients, health care workers, immunocompromised persons, support workers, and the elderly and the young. Antivirals (notably oseltamivir) are currently in very short supply and so will only be provided to treat those who are already ill; antivirals will not be used for prophylaxis.

The ACPWG recommends that the distribution plan for antivirals and vaccines be completed as soon as feasible to ensure coordination with ambulatory care providers and their planning efforts. Any interim plans should be incorporated into local clinical guidelines. Priority groups must be clearly defined to enable providers to give consistent messages to patients and to properly manage patients.

IV. Assure that pediatric in-patient services are available in each of the three emergency zones.

Currently, in-patient pediatric services in King County are limited to Children's Hospital & Medical Center (including beds at Evergreen Medical Center in Kirkland), Swedish Medical Center, and Eastside Hospital–Group Health; Mary Bridge Medical Center in Tacoma provides pediatric care for many residents of south King County. Capacity is extremely limited outside Seattle. The ACPWG supports the efforts of local hospitals in developing pediatric surge capacity to manage extremely ill children by zone.

V. Assure that transportation services are available to bring extremely ill persons to hospitals and alternate care facilities.

The Tacoma-Pierce County Health Department has developed model for shuttling ill patients. The ACPWG recommends that the Healthcare Coalition explore with King County Metro the possibility of providing a dedicated shuttle service for King County patients.

Payment, Reimbursement, and Workers Compensation

Scope

The scope of payment and reimbursement is to identify mechanisms for enabling providers to care for any ill patients during an emergency. The scope of Workers Compensation is to assure that health care workers are supported during and after a pandemic.

Principles

The highest priority is to assure access to care. Therefore, in an emergency, patients must have equal access to medical care, regardless of whether or not they have insurance or a pre-existing provider. However, providers must not be penalized for extending services broadly in an emergency. Therefore, it is essential that providers share responsibility equally for providing care to patients who lack insurance or a primary provider, and that providers are fairly reimbursed for services rendered in an emergency.

Providers and support staff who continue to work during a pandemic are more likely to be exposed to influenza. These individuals must be assured support for time lost due to such increased exposure to influenza.

Plan of Action until future plans are complete

All providers should approach third party payers now to develop agreements for:

a. Suspending or extending submission deadlines during a pandemic
b. Enabling patient coverage for non-network providers
c. Reimbursing for telephone triage

Providers should expect that Workers Compensation will not cover employee salaries for time lost due to influenza-like illness.

Future Planning Goals

I. Increase third-party payer flexibility to equitably distribute care and compensation for care of patients during a public health emergency.

To encourage providers to extend services broadly during an emergency, Public Health and the Healthcare Coalition should work with medical societies, the Washington State Insurance Commissioner, and insurers to establish emergency coverage of provider services during a pandemic. Specifically, third party payers should:

a. Suspend or extend submission deadlines during a pandemic
b. Enable patient coverage for non-network providers
c. Reimburse for telephone triage
d. Simplify documentation requirements for billing during emergencies

The ACPWG supports the Healthcare Coalition creation of a separate working group be devoted specifically to reimbursement issues.

II. Assure that health care workers have financial support to protect them if they acquire illness while working during a pandemic.

Some health care workers may be injured or acquire illness during a public health emergency. Under ordinary circumstances, Workers Compensation provides financial support only if a direct link can be established between the injury and the job. However, during a pandemic, health care workers will place themselves at-risk for serious illness. These workers and their families must be confident that they will not be penalized financially for their professional efforts to care for others. Public Health and the Healthcare Coalition should explore with the Washington State Department of Labor & Industries if Workers Compensation is feasible for health care workers who are unable to continue working due to influenza-like illness acquired during a pandemic.

III. Assurance from malpractice insurance carriers that they will extend coverage to providers acting outside their contracted scope during a pandemic (e.g. pediatricians treating parents of patients).

Ambulatory care providers have expressed a commitment to continuing service to the best of their abilities during a pandemic. However, they are concerned about the risk of a lack of coverage from malpractice if they practice outside the contracted scope of practice. Because there can be no assurance that they will not be sued, the Ambulatory Care Workgroup recommends that PHSKC and the Healthcare Coalition negotiate with the insurance industry to adapt administrative rules during a pandemic.

Alternate Care Facilities and Volunteer Staffing

Scope

The scope of alternate care facilities is to determine what alternate care facilities may be needed during a major communicable disease emergency. The scope of volunteer staffing is to determine how to augment public health and medical staffing at alternate care facilities and other sites during any public health emergency.

Principles

In many public health emergencies, the health care system may be overwhelmed. Hospitals and clinics may be incapacitated. It may be necessary to redirect patients from hospitals to other sites. Alternate care sites must be available in such circumstances. At the same time, in responding to communicable disease emergencies (including a severe influenza pandemic), the health care system must avoid congregating community members. During communicable disease emergencies, the highest priority will be to help infected patients receive care, including palliative care, at home. When hospital care is not available and measures are needed beyond what can be provided at home (as when simple intravenous hydration is the key life-saving treatment), alternative care sites must be designed to avoid exposing uninfected persons to infectious persons.

Plan of Action until future plans are complete

Depending on the severity of local influenza,

Tier 1: The Director of Public Health will determine if Public Health facilities should be redirected to serve as "flu clinics".

Tier 2: Together with the chief executive officers of the major hospitals, the Director of Public Health will facilitate the opening of alternate care facilities and call for volunteers. These facilities must provide:

- **Bed capacity and spatial separation of patients**
- **Facilities and supplies for hand hygiene**
- **Lavatory and shower capacity for large numbers of patients**
- **Food services (refrigeration, food handling, and preparation)**
- **Medical services**
- **Staffing for patient care and support services**
- **Personal protective equipment supplies**
- **Cleaning/disinfection supplies**
- **Environmental services (linen, laundry, waste)**
- **Safety and Security**

Tier 3: Providers must check Info X alerts and the Public Health website for further information.

Future Planning Goals

I. Assure outpatient medical care will be available when traditional health care facilities are overwhelmed.

In a pandemic, it is likely that the entire health care system will be overwhelmed. To reduce the demand on hospitals, alternate care facilities will be needed. These facilities must be geographically distributed throughout the county, must be capable of providing both triage and high-level outpatient care, and must be extremely efficient in providing care to large numbers of patients. In a pandemic, it is likely that ventilators and other life-support equipment will not be available. In this setting, palliative care would be provided at home or at alternate care facilities.

The Ambulatory Care Workgroup recommends that planning for alternate care facilities should be conducted within the three emergency management zones, identifying a lead agency in each zone responsible for managing one or more sites in its zone. This agency should have experience in managing large care facilities. Each facility must provide sufficient:

- Bed capacity and spatial separation of patients
- Facilities and supplies for hand hygiene
- Lavatory and shower capacity for large numbers of patients
- Food services (refrigeration, food handling, and preparation)
- Medical services
- Staffing for patient care and support services
- Personal protective equipment supplies
- Cleaning/disinfection supplies
- Environmental services (linen, laundry, waste)
- Safety and Security

The scenarios in Appendix A must be revised to reflect which alternate care sites are ultimately formally designated (e.g., Public Health Centers or others).

II. Assure adequate staffing for alternate care facilities and other public health response activities.

In most emergencies, but especially in a pandemic, the demand for health care personnel will rise even as those personnel may themselves be less able to respond. Undoubtedly, many health care workers will respond selflessly, working long hours under difficult conditions. However, many facilities may have to limit operations when many employees cannot work. All facilities must make plans to deal with short staffing. However, volunteers may be critical to backfilling for absent staff. In particular, volunteers will likely be critical for alternate care sites.

Staffing for alternate care sites should come from a variety of organizations and should be coordinated through the Regional Medical Resource Center. Efforts are already underway to create a Public Health Medical Reserve Corps that will include physicians and nurses initially, other health care workers as the complex legal issues are addressed. At this time, Corps volunteers will likely be mobilized to serve at sites under Public Health authority for the purpose of addressing traditional public health functions.

The ACPWG requests that Public Health consider the applicability of the PH Medical Reserve Corps planning efforts to a county-wide system. The ACPWG further requests that the Healthcare Coalition begin to consider a staffing system for non-public health functions during a pandemic.

Legal Liabilities

Scope

As with all medical organizations, ambulatory care providers are confronted with legal risks related to changing operational and clinical standards during a pandemic. The scope of the legal issues related to ambulatory care providers includes liability and licensing.

Plan of Action until future plans are complete

All current standards apply at ambulatory care sites.

If ambulatory care providers volunteer under the authority of public health, liability coverage will be extended.

Future Planning Goals

Most providers would be willing to provide care outside their normal scope of practice, if they have clear guidance about standards of care and have assurances that they will be protected against lawsuits. In a pandemic, conditions may be extreme. Providers may have to deny care when resources become limited. The best protection against legal actions from patients demanding care is a strong provider-patient relationship, but these relationships may be challenged during a pandemic or other emergency. Clearly defined and communicated standards of care are also critical, but these may evolve during an emergency and will always be subject to clinical judgment. Limiting legal liability during an emergency is also important. However, health care workers ultimately need assurance that well-intended care provided during emergencies will not threaten their livelihoods, if they find themselves in court.

A Legal Working Group has been convened; it includes representatives from the Washington State Attorney General's Office, the Washington State Department of Health, and local public health agencies. The group is already considering a wide range of legal issues related to system shifts during emergencies. The ACPWG recommends that Public Health and the Healthcare Coalition seek to address the following legal issues.

I. Provide a source of immunity or indemnification for all providers during extreme emergencies.

When extreme emergency situations demand altered standards of care, the ACPWG encourages the indemnification of medical care providers as an alternative to malpractice coverage.

II. Clarify the sources of liability protection for volunteers during emergencies and ensure that they are available to all entities that need volunteers.

The Ambulatory Care Workgroup recommends that avenues for liability protections for Medical Reserve Corps Volunteers be expanded to cover volunteer service regardless of site or lead agency (including telephone triage).